

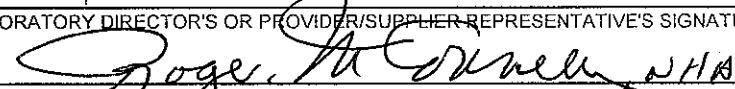
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LTC Residents Protection
PRINTED: 08/05/2009
FORM APPROVED
SEP 01 2009
OMB NO. 0938-0391
Director's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2009
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NAME OF PROVIDER OR SUPPLIER SHIPLEY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2723 SHIPLEY ROAD WILMINGTON, DE 19810
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 279 SS=D	<p>An unannounced QIS annual survey was conducted at this facility from July 6, 2009 through July 10, 2009. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 69. The survey sample totaled 107 residents, which included 40 census residents, 30 admission residents, and 37 stage 2 residents.</p> <p>483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it</p>	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EXECUTIVE DIRECTOR	(X6) DATE 8/30/09
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279

Continued From page 1

was determined that the facility failed to develop a care plan for 2 (R23 and R128) sampled residents. Findings include:

1. R128 was admitted to the facility on 3/18/09 with diagnoses including a fall which resulted in a concussion and supraventricular tachycardia, a rapid heart rhythm. R128 was placed on Plavix, an anticoagulant medication. Record review revealed that the facility failed to develop a care plan for the potential for abnormal bleeding related to the use of Plavix.

On 7/9/09, findings were confirmed with E2, the Director of Nursing and E4, the Corporate Nurse.

cross refer, F312

2. Diagnoses for R23 included blindness. R23 stated during an interview on 7/9/09 that she required staff assistance with her dentures and she only gets the help she needs for her dentures about once a week.

The 6/09 physician order sheet stated, "Have CNA remove dentures HS (at bedtime), clean and place in denture cup." The information was also listed on the 7/09 treatment administration record, used by nurses.

During an interview with E7 (CNA) on 7/9/09, she stated that she did not know that R23 had dentures.

Review of R23's care plan, however, revealed that the facility failed to care plan for the resident's dentures. On 7/10/09, findings were reviewed with administrative staff at the informational meeting.

F 280

483.20(d)(3), 483.10(k)(2) COMPREHENSIVE

F 279

F279

1. A care plan for anticoagulation therapy was initiated on 7/9/09 immediately upon being informed by the surveyor for R128. R128 remains on anticoagulant therapy and care plan is current to meet resident's needs. R23 care plan will be revised to include denture care as per physician orders. A care plan review meeting will be held with all the caregivers providing care for R23 to ensure that the care plan interventions are implemented.

2. All residents have the potential to be affected by this cited practice.

3. The Director of Nursing/Nurse Designee will complete an audit of all residents on anticoagulation therapy to assure that care plans are in place and current to resident's needs.
All residents will be assessed for oral care needs and care plans will be revised to reflect needs.
All current licensed nursing staff and direct care staff will be provided with an educational in-service on the care planning process.
A care plan review meeting will be held weekly between the charge nurse and CNAs assigned to the residents to ensure that all resident's care needs are being met. Care plans will be revised as warranted during meeting to ensure resident's current needs are addressed.

4. A random audit of care plans will be conducted monthly on 10% of the facility's population to ensure care plans are current and meets resident's needs by the DON/ Nurse Designee. A resident interview or observation will be done as well to ensure interventions have been implemented. Staff interviews will be conducted to ensure compliance with the care plan process. The DON/Nurse Designee will provide ongoing monitoring of the care plans in the weekly IDT meetings. Findings will be reported to the NHA for review in the monthly Quality Assurance meeting with corrective action as warranted. Completion Date 9/14/09

F 280

9-14-09

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F 280
SS=D

Continued From page 2
CARE PLANS

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interviews it was determined that the facility failed to revise the care plans for 2 (R23 and R169) sampled residents. Findings include:

1. R23's care plan, dated 4/14/09, was reviewed regarding, "Episodes of Anxiety R/T (related to) bipolar, manipulative behavior, blindness." The plan of action included, "medicate as ordered: Depakote (for bipolar disorder)."

A psychiatric (psych) consult, dated 4/7/09, for "mood instability" stated that R23 was to continue

F 280

F280

1. Resident R23's and R169 care plans have been updated and revised to reflect the current changes in their plan of care and have been reviewed with the interdisciplinary team to ensure interventions are implemented appropriately. E9 and E10 will be educated on the importance of communication of changes in resident's plan of care.
2. All residents have the potential to be affected by this cited practice.
3. All current licensed nursing staff and direct care staff will be provided with an educational in-service on the care planning process and communication of changes in residents' plan of care. A care plan review meeting will be held weekly between the charge nurse and CNAs assigned to the residents to ensure that all resident's care needs are being met. Care plans will be revised as warranted during meeting to ensure resident's current needs are addressed.
4. A random audit of care plans will be conducted monthly on 10% of the facility's population to ensure care plans are current and meets resident's needs by the DON/Nurse Designee. A resident interview or observation will be done as well to ensure current interventions have been implemented on the charts audited. Staff interviews will be conducted by the DON/Nurse Designee to ensure compliance with the care plan process. The DON/Nurse Designee will provide ongoing monitoring of the care plans in the weekly IDT meetings. Findings will be reported to the NHA for review in the monthly Quality Assurance meeting with corrective action as warranted.

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9-14-09

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Continued From page 3

Ativan (for anxiety) prn (as needed). On 5/5/09, a psych consult stated that R23 was no longer on Depakote (discontinued on 4/23/09) and she was to continue Ativan prn.

Review of the 7/09 POS (physician order sheet) revealed that R23's Ativan was ordered on 3/10/09.

The facility failed to revise R23's care plan to update changes in psych medications; to discontinue the Depakote and add prn Ativan. On 7/10/09, findings were reviewed with administrative staff at the informational meeting.

2. R169 was observed in her room on 7/10/09 with a tab alarm on her chair. E9 (CNA) had been in the room previously to assist R169 to the bathroom, but did not reattach the alarm. After E9 was asked if R169 had an alarm in place, she attached the tab alarm to R169's shirt.

During an interview with E10 (LPN) on 7/10/09, she stated that R169 should have a tab alarm and a Posey bed alarm. She checked and found no bed alarm. E10 also checked the MAR (medication administration record), which showed "No devices" under the residents name.

Review of R169's care plan for "at risk for falls", dated 6/9/09, listed approaches including both tab and Posey bed alarms.

The facility failed to revise R169's fall care plan to discontinue the alarms she no longer needed. On 7/10/09, findings were confirmed by E2 (Director of Nursing) and E3 (Assistant Director of Nursing) when they stated that R169 doesn't need the alarms anymore and her care plan should have

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F 280 Continued From page 4
been updated.

F 312 483.25(a)(3) ACTIVITIES OF DAILY LIVING
SS=D

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on resident and staff interviews, it was determined that the facility failed to provide the necessary services to maintain good oral hygiene for 1 resident (R23) unable to carry out activities of daily living without staff assistance. Findings include:

R23's diagnoses included near total vision impairment and Friedreich's ataxia (progressive damage to the nervous system which affects muscle movement to the arms and legs causing incoordination).

Review of the quarterly MDS (minimum data set) assessment, dated 4/8/09, stated that R23 had modified independence (some difficulty in new situations only) in cognitive skills for daily decision-making. She had no memory impairment. R23 required extensive staff assistance with personal hygiene, including brushing her teeth.

The 6/09 physician order sheet stated, "Have CNA remove dentures HS (at bedtime), clean and place in denture cup." The information was also listed on the 7/09 TAR (treatment administration record), used by nurses.

F 280

F 312 F312

1. Resident R23 is now receiving denture and oral care daily and as needed or requested. E7 has been counseled and in-serviced on R23's plan of care.
2. All residents have the potential to be affected by this cited practice.
3. All current license staff and direct care staff will be in-serviced on the importance of communicating changes in residents care and the proper utilization of the 24hour report and Shift Change report.

A care plan review meeting will be held weekly between the charge nurse and CNAs assigned to the residents to ensure that all resident's care needs are being met. Care plans will be revised as warranted during the meeting to ensure resident's current needs are addressed.
Oral care needs will be added to the CNA flow sheets to ensure documented evidence of care provided and flow sheets will be reviewed weekly by the DON/Nurse Designee for compliance.
4. Random Audit of the resident care flow sheets will be conducted monthly on 10 % of the facility's resident population by the DON/Nurse Designee to ensure compliance. A resident interview or observation will be done as well to ensure current interventions have been implemented on the charts audited. Staff interviews will be conducted by the DON/Nurse Designee to ensure compliance with the care plan process. The DON/Nurse designee will monitor the audit outcomes monthly. Findings will be reported to the NHA for review in the monthly Quality Assurance meeting with corrective action as warranted.

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F 312	Continued From page 5 During interviews with R23 on 7/9/09, she stated that she needs assistance with cleaning her dentures and staff only help her with her dentures about once a week. She additionally stated that she sometimes goes to bed with her dentures in if the CNA does not help her take them out to clean them. She stated that she went to bed with her dentures in last night; while her assigned CNA (E8) put her to bed, another CNA showered her earlier in the evening. During an interview with E2 (Director of Nursing) and E3 (Assistant Director of Nursing) on 7/9/09, it was confirmed that denture care is not documented on the TAR, it is an FYI and denture care is not specifically documented on the CNA sheets either. During an interview with E7 (CNA) on 7/9/09, she stated that she did not know that R23 had dentures. The facility failed to provide oral care for R23 despite being assessed for and requiring extensive assistance by the staff.	F 312			
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329			

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F 329 Continued From page 6

resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review and interview, it was determined that the facility failed to ensure that 1 (R128) sampled resident had a drug regimen free of unnecessary drugs. The facility failed to have adequate indications for use and monitoring of the medications, Seroquel and Ambien, including adverse consequences. The facility failed to have an acceptable diagnosis for the administration of the hypnotic medication, Ambien, ordered by the physician on 6/23/09. These medications placed R128 at risk for side effects, including falls. Findings include:

R128 was readmitted to the facility from the hospital on 6/19/09 with a physician's order for Seroquel. Diagnoses included dementia, depression, chronic obstructive pulmonary disease and hypertension. A psychiatric consult during hospitalization, dated 6/5/09, listed diagnoses as, "depressive disorder... without psychotic features, rule out dementia, Alzheimer's type with depression". Although R128 had these

F 329

F329

1. Resident R128's drug regimen was reviewed by the physician to determine indications for use of Ambien and Seroquel. Orders have been written for indications and has been placed on the MAR and physician order sheet. R128 remains on Ambien and Seroquel and behavior monitoring has been implemented. A medication review will be done quarterly to determine efficacy and continue need for use.
2. All residents have the potential to be affected by this cited practice.
3. A letter will be sent to all attending physicians regarding the need for indications for all drug use. A list of all residents on psychopharmacological medications will be obtained from pharmacy and a medication audit review will be completed on all residents. The behavior review committee will meet and review all residents on psychotropic's to determine effectiveness, appropriate indication for use of drugs, and that the targeted behavior is care planned with appropriate interventions, and to determine if medication reduction is warranted. Reviews will be completed by 9/14/09 and findings will be reported to the DON for corrective action as warranted. All current license staff nurses will be provided an in-service on the facility's Unnecessary Medication Policy, and on the Psychopharmacological Medication Policy. The facility's Behavior Review Committee's goals and objectives will be in-serviced to the interdisciplinary team.
4. Monthly random audits of the Medication administration record, physician orders, and care plans will be done on 10% the facility's resident population will be completed by the DON/Nurse Designee to ensure compliance. Findings will be reported to the NHA in the monthly QA meeting with corrective action as warranted.

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9-14-09

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diagnoses, she did not have a diagnosis that was acceptable for the use of Ambien.

Seroquel side effects include unusual changes in behavior, psychomotor restlessness, agitation and insomnia. Additionally, Ambien was ordered by the physician on 6/23/09 and side effects include abnormal thinking and behavioral changes, sedative effects and accidental falls.

While R128 complained of being tired and had 3 falls in a week on 6/21, 6/25 and 6/27/09, she remained on Seroquel without an identification of possible side effects. A Nurses' Note (NN), dated 6/22/09, stated, "note put in MD book requests for Ambien and Xanax". A physician's order for Ambien was written on 6/23/09, and it was administered to R128 on 6/23/09 and 6/24/09. Xanax was not ordered.

On 6/25/09, R128 got up from her wheelchair and lowered herself to the floor, laying on her side. In the facility incident report, dated 6/30/09, the resident stated, "I just wanted to lay down, I was tired." Additionally, a NN, dated 7/1/09, stated, "... She visited mother this past weekend. Res. (resident) began undressing in front of guests, picking her nose and swearing. Daughter states this is completely out of character for res... Enc. to make appt. ASAP for psych med (psychiatric medication) review. Daughter obtained appt. for July 13".

The facility failed to have appropriate diagnoses for the use of Ambien. The facility failed to monitor R128 for adverse effects from the medications specifically unusual behavior and falls.

On 7/9/09, findings were acknowledged by E2,

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F 329	Continued From page 8	F 329		
F 425 SS=D	<p>the Director of Nursing, E3, the Assistant Director of Nursing, and E4, the Corporate Nurse.</p> <p>483.60(a),(b) PHARMACY SERVICES</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and interview, it was determined that the facility failed to provide pharmaceutical services that included procedures to assure the accurate administration of all drugs for 1 (R86) sampled resident. The pharmacy failed to note the change of dose of Combivent, an inhaled medication that relaxes muscles in the airways and increases air flow to the lung, for R86. Findings include:</p> <p>R86 was admitted to the facility on 6/13/09 with</p>	<p>F 425</p> <p>F425</p> <ol style="list-style-type: none"> 1. R86's physician order sheet and MAR were immediately corrected at time surveyor's discovery for the Combivent medication. R86 remains in facility had had no adverse affect from cited practice. Pharmacy staff re-educated on the proper review of new orders and transcription. License staff that completed the Monthly recap of orders will be counseled and re-educated on the recapitulation of monthly medications orders procedure. Facility continues to provide a pharmaceutical service that meets the needs of the resident. 2. All residents have the potential to be affected by this cited practice. 3. All license staff will be re-educated on the Recapitulation of monthly medication orders procedure. An audit will be completed on current residents' physician orders for the last 2 months to ensure accurate transcription of orders by pharmacy. 4. Monthly random audits of the medication administration record, physician order sheets against the medication labels in the medication cart will be completed on 10% of facility's resident population by the DON/Designee. The DON/Nurse Designee will provide ongoing monitoring of the drug reviews completed by the consultant pharmacist. Findings will be reported to the NHA in the monthly QA meeting with corrective action as warranted. <p>Completion Date 9/14/09</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 425 Continued From page 9
diagnoses including chronic obstructive pulmonary disease. On 6/13/09, the physician order was written for Combivent inhale 2 puffs four times daily. On 6/15/09, the physician changed the Combivent order to 1 puff four times a day.

On 7/8/09 at 7:15 PM, during a Medication Pass Observation, E12, an LPN, incorrectly administered 2 puffs of Combivent inhaler to R86.

When the Physician Order Sheet (POS) and the Medication Administration Record (MAR) for the month of July were generated by the pharmacy, Combivent was incorrectly written as 2 puffs four times daily, instead of 1. Consequently, R86 was incorrectly administered 2 puffs of Combivent four times a day from 7/1/09 through 7/8/09.

F 425

F 428
SS=D

483.60(c) DRUG REGIMEN REVIEW

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

F 428

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2009
NAME OF PROVIDER OR SUPPLIER SHIPLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2723 SHIPLEY ROAD WILMINGTON, DE 19810		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 428	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that during the monthly drug regimen review, the licensed pharmacist failed to identify and report irregularities for two (R120 and R128)sampled residents. Findings include: 1. On 7/9/09 during the Med (medication) Pass Observation, R120 was administered OsCal (calcium and vitamin D). The preprinted label (from the pharmacy) on the blister pack of medication incorrectly stated that it was given for anemia. The 7/09 Physician Order Sheet (POS), original physician order, dated 6/5/09, and the 7/09 Medication Administration Record all incorrectly stated that OsCal was given for anemia, also. E6 (RN that wrote the 6/5/09 order which was then signed by an MD) was interviewed on 7/9/09 after the med pass about the use of OsCal to treat anemia. E4 subsequently called the MD on 7/9/09 and obtained a physician order to "change diagnosis for Os-Cal 500 mg from anemia to osteoporosis." Review of the 6/19/09 Drug Regimen Review/Pharmaceutical Care (done monthly) by a licensed pharmacist, failed to identify that OsCal was ordered for an incorrect diagnosis on 6/5/09. Consequently, the pharmacist failed to report the irregularity to the facility so the diagnosis could be	F 428	<p>F428</p> <ol style="list-style-type: none"> 1. R120 remains on Oscal and indication for use has been corrected. Current indication is for use is for treatment of osteoporosis. Consultant pharmacist will be re-educated on proper review of drug regimens and indications. 2. All resident has the potential to be affected by this cited practice. 3. The Consultant will review all current resident's drug regimens monthly for facility's compliance with appropriate clinical indications for use of medications, 4. The DON/Nurse Designee will conduct monthly random audits of physician orders and medication administration records of 10% of the facility's resident population to ensure that the consultant pharmacist's reviews addresses appropriate indications for medications and addresses appropriate use of psychotropic medications. The DON/Nurse Designee will provide ongoing monitoring of the drug reviews. Findings will be reported to the NHA in the monthly QA meeting with corrective action as warranted. <p>Completion Date 9/14/09</p>		9-14-09

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2009
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NAME OF PROVIDER OR SUPPLIER SHIPLEY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2723 SHIPLEY ROAD WILMINGTON, DE 19810
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F 428

Continued From page 11
addressed.

Findings were confirmed with E4 (corporate
nurse) on 7/9/09.

2. Review of the 6/19/09 Drug Regimen
Review/Pharmaceutical Care (MRR) which is
done monthly by a licensed pharmacist, failed to
identify that R128 was on the anti-psychotic
medication, Seroquel without an appropriate
diagnosis.

The 6/19/09 the MRR noted, "admit today, Meds
Reviewed, NR (no recommendations)". The
pharmacist failed to recognize and report to the
facility the use of an anti-psychotic medication
without an appropriate diagnosis so it could be
addressed.

On 7/9/09, findings were confirmed by E2, the
Director of Nursing, E3, the Assistant Director of
Nursing and E4, the Corporate Nurse.

F 428



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

LTC Residents Protection

SEP 01 2009

Director's Office

STATE SURVEY REPORT

Page 1 of 5

NAME OF FACILITY: Shipley Manor

DATE SURVEY COMPLETED: July 10, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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The State Report incorporates by reference and also cites the findings specified in the Federal Report.

An unannounced QIS annual survey was conducted at this facility from July 6, 2009 through July 10, 2009. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 69. The survey sample totaled 107 residents, which included 40 census residents, 30 admission residents, and 37 stage 2 residents.

**Regulations for Skilled and Intermediate Care
Nursing Facilities**

Services to Residents

General Services

The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.

State 3201.6.1.1

1. A care plan for anticoagulation therapy was initiated on 7/9/09 immediately upon being informed by the surveyor for R128. R128 remains on anticoagulant therapy and care plan is current to meet resident's needs. R23 care plan will be revised to include denture care as per physician orders. A care plan review meeting will be held with all the caregivers providing care for R23 to ensure that the care plan interventions are implemented.
2. All residents have the potential to be affected by this cited practice.
3. The Director of Nursing/Nurse Designee will complete an audit of all residents on anticoagulation therapy to assure that care plans are in place and current to resident's needs. All residents will be assessed for oral care needs and care plans will be revised to reflect needs. All current licensed nursing staff and direct care staff will be provided with an educational in-service on the care planning process. A care plan review meeting will be held weekly between the charge nurse and CNAs assigned to the residents to ensure that all resident's care needs are being met. Care plans will be revised as warranted during meeting to ensure resident's current needs are addressed.
4. A random audit of care plans will be conducted monthly on 10% of the facility's population to ensure care plans are current and meets resident's needs by the DON/Nurse Designee. A resident interview or observation will be done as well to ensure interventions have been implemented. Staff interviews will be conducted to ensure compliance with the care plan process. The DON/Nurse Designee will provide ongoing monitoring of the care plans in the weekly IDT meetings. Findings will be reported to the NHA for review in the monthly Quality Assurance meeting with corrective action as warranted. Completion Date 9/14/09

9-14-09

Provider's Signature

Bob McConnell
NHA

Title Executive Director

Date 8-30-2009



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STATE SURVEY REPORT

DATE SURVEY COMPLETED: July 10, 2009

NAME OF FACILITY: Shipley Manor

ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies
3201. 6.5	<p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey, date completed 7/10/09, F312, F 329</p> <p>Nursing Administration</p>
3201.6.5.7	<p>The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey, date completed 7/10/09, F279, F280.</p> <p>Pharmacy Services</p>
3201. 6.10	<p>Each nursing facility shall have a consultant pharmacist who shall be responsible for the general supervision of the nursing facility's pharmaceutical services.</p>
3201.6.10.1	

State 3201.6.5.7

1. Resident R23's and R169 care plans have been updated and revised to reflect the current changes in their plan of care and have been reviewed with the interdisciplinary team to ensure interventions are implemented appropriately. E9 and E10 will be educated on the importance of communication of changes in resident's plan of care.
2. All residents have the potential to be affected by this cited practice.
3. All current licensed nursing staff and direct care staff will be provided with an educational in-service on the care planning process and communication of changes in residents' plan of care. A care plan review meeting will be held weekly between the charge nurse and CNAs assigned to the residents to ensure that all resident's care needs are being met. Care plans will be revised as warranted during meeting to ensure resident's current needs are addressed.
4. A random audit of care plans will be conducted monthly on 10% of the facility's population to ensure care plans are current and meets resident's needs by the DON/Nurse Designee. A resident interview or observation will be done as well to ensure current interventions have been implemented on the charts audited. Staff interviews will be conducted by the DON/Nurse Designee to ensure compliance with the care plan process. The DON/Nurse Designee will provide ongoing monitoring of the care plans in the weekly IDT meetings. Findings will be reported to the NHA for review in the monthly Quality Assurance meeting with corrective action as warranted.

Completion Date: 9/14/09

9-14-09



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STATE SURVEY REPORT

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DATE SURVEY COMPLETED: July 10, 2009

ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED													
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies												
16 Del. C., Chapter 11, §1162,	<p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey, date completed 7/10/09 F425, F428.</p> <p>Nursing Staffing</p> <p>(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.</p> <p>Nursing staff must be distributed in order to meet the following minimum shift ratios:</p> <table><tr><th></th><th>RN/LPN</th><th>CNA*</th></tr><tr><td>Day</td><td>1:15 residents</td><td>1:8 residents</td></tr><tr><td>Evening</td><td>1:23</td><td>1:10</td></tr><tr><td>Night</td><td>1:40</td><td>1:20</td></tr></table> <p>* or RN, LPN, or NAIT serving as a CNA.</p>		RN/LPN	CNA*	Day	1:15 residents	1:8 residents	Evening	1:23	1:10	Night	1:40	1:20
	RN/LPN	CNA*											
Day	1:15 residents	1:8 residents											
Evening	1:23	1:10											
Night	1:40	1:20											
16 Del.C Chapter 11, 1162	<p>1. The Facility cannot correct the PPD on 20 June 2009.</p> <p>2. No residents are affected by this cited practice.</p> <p>3. The PPD will be tabulated from the past month to validate meeting state requirements or identify any patterns by director of nursing/staff scheduler.</p> <p>The director of nursing/staff scheduler will estimate the ppd for the next day and on Friday for the weekend to validate meeting state required ppd. An audit of the day prior ppd will be performed by the director of nursing/scheduler to ensure meeting the state requirement. The scheduler and supervisors will be in-serviced on state required ppd.</p> <p>If Staff calls off on weekends, we have an on-call nurse to contact and a list of nurses and CNA's to fill the vacancy.</p> <p>4. The result for the ppd monitoring will be reported to the Quality Assurance Committee for their review.</p> <p>9-14-09</p>												



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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(g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week.

Three weeks of facility staffing, covering the period of 4 June 2009 through 24 June 2009 inclusive, were reviewed to verify compliance with Delaware Nursing Home Staffing Laws, commonly known as Eagles' Law. The review consisted of data entered on the DLTCRP Staffing Worksheets by Shipley staff, and signed by the Administrator. The one (1) citation hereon results from that work.

The law was not met as evidenced by:

Shipley Manor failed to meet the 3.28 daily care hours per resident requirement on the one (1) day below. The daily care hours per resident attained by the provider on the date are parenthesized.

1. Saturday, 20 June 2009 (3.12).



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies